U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 21 April 2006

CASE NO.: 2005-BLA-5379

In the Matter of:

RAYMOND K. CULBERTSON,
Claimant,

v.

CLINCHFIELD COAL COMPANY,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Ron Carson,
For the Claimant

Timothy W. Gresham, Esq.
Tracy Alice Berry, Esq.
For the Employer

Before: STEPHEN L. PURCELL
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 et seq. ("the Act"). Benefits under the Act are awarded to coal miners who are totally disabled due to pneumoconiosis. Surviving dependents of coal miners whose deaths were caused by pneumoconiosis may also recover benefits. Pneumoconiosis, commonly known as black lung, is a chronic dust disease of the lungs arising from coal mine employment. 20 C.F.R. § 718.201 (2004).

On December 20, 2004, this case was referred to the Office of Administrative Law Judges for a formal hearing. (DX 47). Following proper notice to all parties, a hearing was held

on May 11, 2005 in Big Stone Gap, Virginia. The Director's exhibits 1-49,[1] Claimant's exhibit 2,[2] and Employer's exhibits 1-6,[3] 12-24,[4] and 27-34 were admitted into evidence pursuant to 20 C.F.R. § 725.456. Tr. 6-36. The parties had full opportunity to present closing arguments in the form of post-hearing briefs. Claimant's closing argument was received on June 20, 2005, and Employer's closing argument was received on July 21, 2005.

The Findings of Fact and Conclusions of Law that follow are based upon my analysis of the entire record, the arguments of the parties, and the applicable regulations, statutes, and case law. They also are based upon my observation of the demeanor of the witness who testified at the hearing. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. While the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformance with the quality standards of the regulations.

The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. References to DX, CX, and EX refer to the exhibits of the Director, Claimant, and Employer, respectively. The transcript of the hearing is cited as "Tr." and by page number.

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[1] The Director's exhibits include multiple chest x-ray readings, pulmonary function studies, arterial blood gas tests, and medical opinions submitted by Claimant and Employer in the prior closed claims. The parties were informed that these items would be excluded from the evidentiary record and not considered in deciding the instant claim to the extent they were not expressly identified by the parties as evidence in this claim and either complied with the evidentiary limitations of § 725.414 or were admissible for good cause. Tr. 17-18, 19.

[2] CX 1, a chest x-ray reading by Dr. Michael S. Alexander, was submitted post-hearing by Claimant's representative as "rehabilitative" evidence pursuant to 20 C.F.R. § 725.414(a)(2)(ii) which provides, in relevant part, "where the responsible operator . . . has submitted rebuttal evidence . . . with respect to medical testing submitted by the claimant, the claimant shall be entitled to submit an additional statement from the physician who originally interpreted the chest X-ray . . . ." Employer objected to CX 1 arguing that it was not "rehabilitative" evidence in that it was simply an ILO form containing a re-reading of the March 24, 2004 x-ray previously interpreted by Dr. Alexander which in no way responded to the rebuttal evidence (a reading of the March 24, 2004 x-ray by Dr. William W. Scott contained in DX 36) submitted by Employer relating to Dr. Alexander's original interpretation. I agree with Employer that CX 1 is not a "statement" within the meaning of § 725.414(a)(2)(ii) inasmuch as the form contains no reference to the interpretation of Dr. Scott submitted by Employer. The exhibit is thus excluded.

[3] EX 7-11 were excluded as exceeding the evidentiary limitations of the amended regulations and because Employer failed to establish good cause for their admission into evidence. Tr. 17-19.

[4] EX 25 is a reading of an October 31, 2000 CT scan by Dr. Gregory Fino. EX 26 is a reading of a June 20, 2001 CT scan by Dr. Shiv Navani. In *Webber v. Peabody Coal Co.*, BRB No. 05-0335 (Jan. 27, 2006)(*en banc*) ("*Webber*"), the Board held that Section 718.107(a) "is reasonably interpreted to allow for the submission, as part of a party's affirmative case, of *one* reading of each separate test or procedure undergone by claimant . . . [and] each party may choose which set of results to submit, for each test or procedure, in order to best support its position." *Webber*, slip op. at 8 (italics added). The Board did not distinguish between "other medical evidence" created during the course of a claimant's treatment for a pulmonary condition or evidence created to support or defeat a claim for black lung benefits. Inasmuch as EX 25 and 26 are duplicate readings of EX 23 and 21, respectively, EX 25 and 26 are excluded from the evidentiary record.

Issues

The following issues are presented for resolution:

1) Whether Claimant has pneumoconiosis;

2) Whether Claimant's pneumoconiosis arose out of coal mine employment

3) Whether Claimant is totally disabled;

4) Whether Claimant's disability is due to pneumoconiosis; and

5) Whether the evidence establishes that an applicable condition of entitlement has changed since the prior denial of benefits as required by 20 C.F.R. §725.309(d).

The Employer also contests "other issues" identified in item 18 on the list of issues. DX 47. These issues are beyond the authority of an administrative law judge and are preserved for appeal. The Employer withdrew the issue of timeliness of the filing of the instant claim and conceded 23 years of coal mine employment. Tr. 5.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Procedural History

This is Claimant's fourth claim for benefits under the Act. His first claim, filed on October 10, 1978, was denied as abandoned on October 4, 1979. DX 1 (DX 41 at 2; DX 72 at 1).[5]

On July 28, 1986, Claimant filed his second claim for benefits which was denied by the District Director on November 26, 1986 because the evidence failed to establish any element of entitlement or a material change in condition. DX 1 (DX 73).

Claimant filed his third claim for benefits on December 6, 1996 (DX 1; *see also* DX 74), and the claim was thereafter denied by Administrative Law Judge Richard A. Morgan on May 27, 1998 because Claimant failed to establish any element of entitlement or a material change in condition. DX 1 (DX 41).

On April 5, 1999, Claimant filed a request for modification. DX 1 (DX 37 at 1). A proposed decision and order denying modification was issued by the District Director on June 29, 1999 based on Claimant's failure to establish a change in condition or a mistake of fact. DX 1 (DX 46).

[5] Numbers listed in parenthesis in this decision following a reference to "DX 1" refer to the former Director's exhibit numbers contained within DX 1.

On June 8, 2000, Claimant again filed a request for modification. DX 1 (DX 49 at 1). On August 24, 2000, the District Director again denied modification based on Claimant's failure to establish a change in condition or a mistake of fact. DX 1 (DX 57 at 1).

On August 20, 2001, Claimant again filed a request for modification. DX 1 (DX 57[6] at 1). On October 11, 2001, the District Director again denied modification based on Claimant's failure to establish a change in condition or a mistake of fact. DX 1 (DX 68 at 1). On November 6, 2001, Claimant requested a formal hearing. DX 1 (DX 67). On July 3, 2002, Claimant requested that he be permitted to withdraw "this entire claim for Federal Black Lung Benefits [pursuant to the Administrative Law Judge Hearing dated 06/25/02 in Abingdon, VA]." DX 1 (DX 1 at 4). Administrative Law Judge Richard T. Stansell-Gamm thereafter issued an order dated July 10, 2002 granting Claimant's unopposed motion to withdraw his claim. DX 1 at 1.

Claimant filed the instant claim for benefits on July 11, 2003 (DX 4). A Proposed Decision and Order awarding benefits was issued by the District Director on August 2, 2004. DX 39. In a letter dated September 8, 2004, Employer requested a formal hearing. DX 44. The case was transferred to the Office of Administrative Law Judges on December 20, 2004 (DX 47), and a formal hearing was held on May 11, 2005 in Big Stone Gap, Virginia.

Claimant was born on March 29, 1937 and was 68 years of age at the time of the hearing. Tr. 41. He completed the 7th grade and subsequently obtained his GED. *Ibid*. Claimant is 6'1" in height, weighs approximately 239 pounds, and served in the U. S. Marine Corps from 1954 to 1958. *Ibid*.

Claimant stopped working as a coal miner in September 1996 and was working as a "car dropper" for Clinchfield Coal Company at that time. Tr. 41. His duties in that position involved loading coal from a bin into coal cars, after which he would "climb [onto] the cars, release the brakes and drop the cars down the track." Tr. 41-42. He performed that job for the last three years he worked as a coal miner. His duties involved climbing onto and off of the coal cars, a "whole lot of lifting," and "beat[ing]the doors so they would close on the coal cars, because they would push them up in there with the doors open and we would have to take a large bar and close the doors." Tr. 42. It was "very dusty" working in the loading house and "all the dust would come back on me as we went down the holler [in the coal cars]." *Ibid*. Claimant worked eight hours a day and five or six days a week. Tr. 43. He occasionally wore a respirator but "[c]ouldn't hardly breath with a respirator on." *Ibid*. He left the mine in 1996 because the mine shut down. *Ibid*.

According to Claimant, he began having breathing problems about 19 years ago, around 1986. Tr. 43. He had breathing problems when he retired in 1996, and Dr. Henry, who was treating him at the time, put him on inhalers. Tr. 43-44. He is presently taking medication for his breathing problems and uses an inhaler. Tr. 44. Claimant previously smoked cigarettes for about 20 to 25 years but quit about eight years ago. Tr. 44-45. He does not think he could perform his prior job as a "car dropper" because of his breathing problems. Tr. 45.

[6] There are two former DX 57's contained in the record.

Claimant did not recall telling Dr. Cox in 1982 that he had been smoking for 20 years at that time. Tr. 45. He smoked "approximately from half to a little better than half a pack a day . . . ." Tr. 46. He denied ever smoking as much as two and a half packs of cigarettes a day. *Ibid*.

Claimant also suffers from heart disease and was first diagnosed with that condition in the late 1970's. Tr. 46. He had a pacemaker implanted about two years ago. Tr. 47.

Coal Mine Employment

The duration of a claimant's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. Claimant bears the burden of proof in establishing the length of his coal mine work. *See Shelesky v. Director, OWCP*, 7 BLR 1-34, 1-36 (1984); *Rennie v. U.S. Steel Corp.*, 1 BLR 1-859, 1-862 (1978). As noted above, Employer has stipulated to the 23 years of coal mine employment found by the District Director. After a review of the record, I accept the Employer's concession and find that Mr. Culbertson has established 23 years of coal mine employment.

Mr. Culbertson testified that his last coal mining job was as a "car dropper" for Clinchfield Coal Company, a position which he held for three years before he retired in September 1996. His duties involved loading coal into coal cars, was "very dusty," and required substantial lifting, bending, and physical exertion. Other positions he held during his employment with Clinchfield included utilityman and repairman. DX 17. Mr. Culbertson further testified that he has not worked since leaving Clinchfield Coal Company.

Responsible Operator

The Employer has not contested that it is the responsible operator in this case. An employment history form completed by Claimant shows that Mr. Culbertson worked for Clinchfield Coal Company from September 1967 to September 1996. DX 5. The record and testimony establish that the claimant did not work as a coal miner after that date. The Social Security records confirm that Claimant worked for the Pittston Company from 1967 through 1980, that Claimant was then employed by Clinchfield Coal Company from 1981 through 1997, and that any employment that followed was not coal mine employment. DX 8. Consequently, I find that Clinchfield Coal Company is the properly designated responsible operator.

Dependents

Claimant noted one dependant, his wife Maxie, on his claim for benefits. DX 4. The issue of dependency was not contested by Employer. DX 47. The marriage certificate filed by Claimant in support of his claim shows that he married Maxie Irene Beaver April 26, 1986 in Wise County, Virginia. DX 10. Pursuant to §§ 725.204 and 725.205, I find that Mrs. Maxie Culbertson qualifies as the miner's spouse and dependent. DX 10, 2. Consequently, I find that Claimant has one dependent for purposes of augmentation of benefits.

Timeliness

Section 725.308 provides, in relevant part, that a claim for benefits shall be filed within three years after a medical determination of total disability due to pneumoconiosis has been communicated to the miner. 20 C.F.R. § 725.308(a). The instant claim for benefits was filed by Mr. Culbertson on July 11, 2003. DX 4. As noted previously, Employer withdrew its controversion of this issue at the hearing. Nothing in the record before me suggests that Claimant was ever informed he was totally disabled by pneumoconiosis more than three years before the date upon which this claim was filed, and Employer has offered no argument to the contrary. I therefore find the claim is timely.

Applicable Law

Claimant filed this claim for benefits on July 11, 2003, and, therefore, entitlement to benefits must be established under the regulatory criteria at Part 718. To be entitled to benefits under Part 718, Claimant must establish by a preponderance of the evidence that (1) he suffers from pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) he is totally disabled; and (4) his total disability is caused by pneumoconiosis. *See Gee v. W.G. Moore & Sons,* 9 BLR 1-4 (1986). Failure to establish any of these elements precludes recovery under the Act.

In addition, in this case, where a claimant has filed more than one claim and the earlier claim was denied, the later claim must also be denied on the grounds of the earlier denial unless the claimant demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. 20 C.F.R. § 725.309(d). Since Claimant failed to establish any condition of entitlement in the prior denial, the evidence will be reviewed to determine if Claimant can now establish that one or more condition of entitlement has changed since the prior denial of May 27, 1998.[7]

[7] As stated above, Claimant's third claim, filed December 6, 1996, was denied by ALJ Morgan in a decision and order on May 27, 1998. DX 1 (DX 41). Applicable regulations provide that a decision shall become final 30 days after the decision is filed in the office of the District Director. 20 C.F.R. § 725.479. Although a final decision and order may thereafter be modified within one year of the final decision based on a change of condition or mistake of fact, 20 C.F.R. § 725.310(a), a claim may not be "withdrawn" after it becomes final. *See Clevenger v. Mary Helen Coal Co*., 22 B.L.R. 1-193 (2002)(en banc) and *Lester v. Peabody Coal Co*., 22 B.L.R. 1-183 (2002(en banc) (holding that once a decision on the merits issued by an adjudication officer becomes effective pursuant to §§ 725.419, 725.479, and 725.502, there no longer exists an "appropriate" adjudication officer authorized to approve a withdrawal request under 20 C.F.R. § 725.306). ALJ Stansell-Gamm's July 10, 2002 order approving withdrawal of Claimant's December 6, 1996 duplicate claim was thus ineffective, and the May 27, 1998 decision of ALJ Morgan is therefore the last final decision prior to when Claimant filed the instant claim for benefits on July 11, 2003. In order to prevail in this subsequent claim, Claimant must therefore establish a change in one or more conditions of entitlement since May 27, 1998.

Medical Evidence

A. X-Ray reports[8]

Exhibit	Date of X-ray	Quality	Physician/ Qualifications	Interpretation
DX 31	3/19/03	1	Cappiello, BCR/B	1/0
DX 36	3/19/03	2	Wheeler, BCR/B	Negative
DX 13[9]	12/9/03	1	Baker, B	1/0
DX 36	12/9/03	2	Scatarige, BCR, B	Negative
DX 37	5/13/04	1	Wheeler, BCR/B	Negative
DX 38	5/13/04	2	Miller, BCR/B	1/0
EX 30	5/13/04		Wheeler, BCR/B	Dr. Miller, *inter alia*, misinterpreted pulmonary vessels in mid and lower lungs as nodules which can be proven with good quality CT scan.
EX 29	3/23/05	1	Wheeler, BCR/B	No CWP
CX 2	3/23/05	2	Ahmed, BCR/B	1/0

B. Pulmonary Function Studies[10]

Exhibit /Date	Physician	Age/ Height[11]	FEV_1	FVC	MVV	FEV_1/ FVC	Date of Study	Comments
DX 31	Smiddy	66 74"	1.86	3.12		59%	8/19/03	Spirometry data is acceptable and reproducible; good patient effort and understanding.
DX 13	Baker	66 72.5"	1.84 1.27	3.40 2.13		54%	12/9/03	
DX 31[12]	Narayanan	66 74"	1.66	2.96	77.5	56%	1/8/04	

[8] A chest x-ray may indicate the presence or absence of pneumoconiosis. 20 C.F.R. § 718.102(a), (b). It is not utilized to determine whether the miner is totally disabled, unless complicated pneumoconiosis is indicated wherein the miner may be presumed to be totally disabled due to the disease.

[9] This x-ray was also read for quality purposes only on 12/19/03 by Dr. Peter T. Barrett, a Board-certified Radiologist and B-reader. DX 14.

[10] The pulmonary function study, also referred to as a ventilatory study or spirometry, indicates the presence or absence of a respiratory or pulmonary impairment. 20 C.F.R. § 718.104(c). The regulations require that this study be conducted three times to assess whether the miner exerted optimal effort among trials, but the Board has held that a ventilatory study which is accompanied by only two tracings is in "substantial compliance" with the quality standards at § 718.204(c)(1). *Defore v. Alabama By-Products Corp.*, 12 BLR 1-27 (1988). The values from the FEV_1 as well as the MVV or FVC must be in the record, and the highest values from the trials are used to determine the level of the miner's disability.

[11] The miner's height was reported variously as ranging from 72.5 to 74 inches. For purposes of determining qualifying disability values, I find that the miner's height equals 73 inches inasmuch as Dr. Hippensteel's report, unlike the other reports, contains an express statement with respect to how the measurement was obtained, *i.e.*, that the Miner was measured at the time of the 5/13/04 examination with his shoes off.

[12] CX 31 also includes a pulmonary function test dated 2/11/03 performed by Pat Stapelton, a Medical Assistant with Stone Mountain Health Services. It is not clear whether this study was conducted as part of Claimant's

Exhibit /Date	Physician	Age/ Height[11]	FEV_1	FVC	MVV	FEV_1/ FVC	Date of Study	Comments
DX 37	Hippensteel	67 73"	1.75 1.87	3.10 3.32	70.0	56% 56%	5/13/04	Syringe & body box calibration performed prior to spirometry; Patient's height and weight measured with shoes off; spirometry data acceptable and reproducible; aerosol tx with UD Albuterol given via HHN with post spirometry performed.

C. Arterial Blood Gas Studies[13]

Exhibit	Date	Physician	pCO_2	pO_2	Resting/ Exercise	Comments
DX 13	12/9/03	Baker	36	76	Resting	
			--	--	Exercise	
DX 37	5/13/04	Hippensteel	38.8	96.3	Resting	Normal gas exchange at rest; carboxyhemoglobin level is normal.
			--	--	Exercise	
EX 29	3/23/05	Castle	34.4	73.7	Resting	Resting ABGs are normal; carboxyhemoglobin level is normal.
			--	--	Exercise	

D. Narrative Medical Evidence

Dr. Ernest M. Henry

According to an October 6, 2002 letter from Dr. Henry, he was asked by Claimant to provide an assessment of his current respiratory impairments. DX 31. Dr. Henry wrote that he had been Mr. Culbertson's primary care physician for 10 years and that Claimant has a significant respiratory impairment. He stated that a pulmonary function test study performed on July 24, 2001 revealed an FEV_1 of 52% of predicted "with slight improvement after bronchodilator suggesting a severe obstructive ventrally [sic] impairment." *Ibid*. He further

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treatment for a pulmonary or respiratory condition or was done in support of his claim for black lung benefits. Furthermore, the record contains no physician's interpretation of the study. Inasmuch as Claimant has offered the interpretations in CX 31 of Drs. Smiddy and Narayanan of the 8/19/03 and 1/8/04 studies, respectively, as the two studies admissible under 20 C.F.R. § 725.414(a)(2)(i) in his affirmative case, and Claimant has not established good cause for exceeding the regulation's limitation, no consideration is given to the 2/11/03 study.

[13] Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. 20 C.F.R. § 718.105(a).

wrote that Claimant had "on his chest x-ray micro nodular change consistent with five lobe pneumoconiosis. This based on a report read by Dr. Joseph Smiddy of Kingsport Pulmonary Associates. The bilateral density seen on his x-ray are [sic] due to his occupational coal dust exposure." *Ibid*. Finally, Dr. Henry wrote:

> [H]is breathing impairment markedly has decreased the patient's quality of life. He has shortness of breath with minimal exertion. He coughs up copious amounts of mucoid secretions in the mornings and in my opinion his pulmonary function has showed a gradual deterioration over time.

Ibid. Dr. Henry is Board-certified in Internal Medicine.

Dr. Glen R. Baker

Dr. Baker, who is Board-certified in Internal Medicine and Pulmonary Diseases, as well as a NIOSH certified B-Reader, performed a pulmonary function examination of the Claimant on behalf of the Department of Labor on December 9, 2003. DX 13. He considered 24 years of coal mine employment as a repairman and car dropper, 20 years of which was underground, and a smoking history of 20 years of one-half pack of cigarettes per day. He noted, *inter alia*, a history of wheezing, chronic bronchitis, and heart disease of 10 to 15 years duration, and hospitalization for bronchitis and pneumonia 5 to 7 years ago. Claimants complaints of symptoms included daily sputum production, wheezing, dyspnea, cough, and orthopnea for 10 to 15 years. Physical findings were essentially normal. Diagnostic testing was interpreted as showing coal workers' pneumoconiosis 1/0, moderate obstructive defect, and mild resting arterial hypoxemia. Dr. Baker rendered diagnoses of, *inter alia*, coal workers' pneumoconiosis based on abnormal chest x-ray and exposure to coal dust, as well as chronic obstructive pulmonary disease ("COPD") and chronic bronchitis which were attributed to coal dust exposure and smoking. He characterized the degree of impairment from respiratory or pulmonary disease as "moderate."

Dr. Kirk E. Hippensteel

Dr. Hippensteel examined Claimant in Richlands, Virginia on May 13, 2004 at the request of Employer and reported his findings in a June 3, 2004 report of that examination. DX 37. He recorded the Claimant's work and medical histories and noted a smoking history of approximately 1½ packs of cigarettes per day beginning at age 25 to 27 and ending about eight years ago. Dr. Hippensteel performed a physical examination, conducted objective testing including a chest x-ray, pulmonary function tests, and arterial blood gas studies, and reviewed various medical reports, including treatment and hospitalization records. Based on his examination and review of the available medical evidence, he concluded with a reasonable degree of medical certainty that Claimant did not have pneumoconiosis caused by his 24 years of coal mine employment and did not suffer from industrial bronchitis. He noted that chronic bronchitis is a disease of the general public and that Claimant suffered from allergies, also a disease of the general public, which contributed to Claimant's bronchitis. He attributed Claimant's obstructive lung disease to his significant cigarette smoking history. Dr. Hippensteel

also noted that Claimant suffered from other significant medical problems unrelated to his lungs which can cause shortness of breath. With respect to impairment, Dr. Hippensteel wrote:

> His heart rhythm disturbance required him to get a pacemaker to help control. He has also been impaired as a whole man from significant degenerative arthritis with bilateral total knee replacement, making him unable to exercise on my examination. These problems have been added to by obesity and diabetes mellitus, also unrelated to his coal mine dust exposure. There is no question that he is unable to go back to work as a whole man from his multiple medical problems, most of which are not related to his lungs. His chronic bronchitis with associated moderate obstructive lung disease currently causes enough pulmonary impairment, however, to keep him from going back to work in the mines, even though, as stated, the evidence is against its relationship to coal workers' pneumoconiosis in this case.

Dr. Hippensteel is a certified B-Reader and is Board-certified in Internal Medicine and Pulmonary Disease, with a subspecialty in Critical Care Medicine.

Dr. Hippensteel was deposed by Employer's counsel on April 25, 2005 and reiterated his findings and conclusions with respect to this case. EX 33. He noted, in part, that arterial blood gas studies conducted by him, Dr. Baker, and Dr. Castle were normal. *Id.* at 19-20. He similarly noted that pulmonary function testing revealed moderate obstruction with minimal improvement post bronchodilator, and that total lung volume capacity was completely normal confirming the presence of an obstructive rather than restrictive lung disease. *Id.* at 21-23. Test results also revealed an essentially normal diffusion capacity. *Id.* at 24. Dr. Hippensteel reiterated his opinion that Claimant's symptoms were not related to coal workers' pneumoconiosis but were instead referable to chronic bronchitis and obstructive lung disease due to Claimant's smoking history and heart disease, all of which were unrelated to coal mine dust exposure. *Id.* at 28.

Dr. James R. Castle

Dr. Castle, who is a NIOSH certified B-reader and Board-certified in Internal Medicine and Pulmonary Disease, performed a pulmonary evaluation of Claimant on March 23, 2005 at Employer's request and reported his findings in a report dated April 12, 2005. EX 29. His report notes Claimant's employment and medical histories, records a smoking history of ½ pack of cigarettes daily for approximately 35 years beginning in his 20's and stopping about nine years ago, and reflects the results of his physical examination and objective tests including a chest x-ray, pulmonary function tests, and arterial blood gas studies. Dr. Castle also reviewed various medical reports, including treatment and hospitalization records. Based on his examination and review of the available medical evidence, he concluded with a reasonable degree of medical certainty that Claimant did not suffer from coal workers' pneumoconiosis. He further opined that Claimant is permanently and totally disabled as a result of tobacco smoke induced chronic airway obstruction but not from coal workers' pneumoconiosis or any other coal mine dust induced lung disease. Dr. Castle agreed with Dr. Hippensteel that Claimant was

permanently and totally disabled as a whole man because of cardiac disease, diabetes, and degenerative arthritis, none of which were related to his coal mine employment.

Dr. Castle was deposed by Employer's counsel on May 6, 2005 and reiterated his findings and conclusions with respect to this case. EX 34. He noted that the results of arterial blood gas studies were normal and pulmonary function test results were consistent with obstructive but not restrictive lung disease. *Id.* at 14-17. He further noted that, although coal mine dust may result in a reduction of diffusion capacity, that was typically seen in the presence of a high degree of profusion of either p or r type opacities on chest x-ray which was not seen in Claimant's case. *Id.* at 16. Dr. Castle stated that Claimant's test results were consistent with an impairment due to smoking, cardiac problems, and obesity. *Id.* at 17. He reiterated his opinion that Claimant did not suffer from coal workers' pneumoconiosis or any other chronic dust disease of the lungs related to or aggravated by coal dust exposure. *Ibid*. Dr. Castle further opined that Claimant suffered from tobacco smoke-induced chronic airway obstruction, cardiac disease, diabetes, and degenerative arthritis, all of which were unrelated to coal dust exposure, and that Claimant could not return to his last job in the coal mines either because of his respiratory condition alone, or in combination with his other medical conditions. *Id.* at 18-19.

E. Hospital and Treatment Records

The record contains multiple medical treatment and hospitalization records including the following:

> Referral for coronary angiogram dated 9/13/77 from University of Virginia Medical Center authored by Dr. Joseph G. Tan reflecting treadmill EKG with negative findings and history of anginal pain claimed by patient to be aggravated by working in coal mines with x-rays, pulmonary function studies, arterial blood gases showing no evidence of black lung. EX 15.
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> Discharge summary from University of Virginia Medical Center dated from 10/16/77 to 10/19/77 reflecting smoking history of 20 pack years and showing diagnoses of, *inter alia*, chest pain, migraine headache, and history of paroxysmal atrial tachycardia. EX 16.
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> Indian Path Hospital consultation report by Dr. Larry H. Cox reflecting a 9/5/82 consult and recording, *inter alia*, social history recording Claimant "smokes up to 2 ½ packs per day but recently had to cut down to 1 pack per day and has smoked for 30 years," and impression of paroxysmal atrial fibrillation occurring mostly with alcoholic binges but occasionally at other times, suspected idiopathic atrial fibrillation but no definite evidence of heart disease, chest pain with reported normal cardiac catheterization 6 years ago and normal treadmill test 2 weeks ago. EX 12.
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> Consult report by Dr. Larry H. Cox dated 9/27/82 on referral from Dr. Dennis Chipman noting, *inter alia*, paroxysmal atrial fibrillation primarily related to binges of alcoholism with possible underlying sick sinus syndrome but no evidence of organic heart disease, normal coronary angiograms at University of Virginia six years ago, and recent normal exercise treadmill test. EX 13.

Consult report by Dr. Larry H. Cox dated 1/16/85 reflecting idiopathic paroxysmal atrial fibrillation and flutter, and chest pain which remained atypical and not suggestive of angina. EX 14.

Lonesome Pine Hospital x-ray report dated March 11, 1985 read by Dr. Subhash Saha as showing linear density at right base suggesting subsegmental plate-like atelectasis but no other abnormalities. EX 1.

Russell County Medical Center hospital records dated from 6/4/86 through 6/6/86 reflecting discharge diagnoses of angina pectoris, arteriosclerotic heart disease with paroxysmal atrial flutter-fibrillation, and sick sinus syndrome. EX 2.

Russell County Medical Center hospital records dated from 6/30/86 through 7/3/86 reflecting discharge diagnoses of angina pectoris, paroxysmal atrial flutter/fibrillation, and arteriosclerotic heart disease with sick sinus syndrome. EX 3.

Russell County Medical Center hospital records dated from 8/17/86 through 8/20/86 reflecting discharge diagnoses of angina pectoris, paroxysmal atrial fibrillation, and arteriosclerotic heart disease with sick sinus syndrome. EX 4.

Russell County Medical Center hospital records dated from 9/4/86 through 9/7/86 reflecting discharge diagnoses of chest pain, myocardial infarction excluded, arteriosclerotic heart disease with atrial fibrillation, and gastritis. EX 5.

Russell County Medical Center portable chest x-ray dated 9/4/89 reflecting heart, mediastinum and lungs normal. EX 6.

Chest x-ray report from Russell County Medical Center dated 8/26/97 reflecting impression of no active or acute cardiopulmonary disease. EX 19.

Chest x-ray report from Russell County Medical Center dated 10/22/98 reflecting impression of no active or acute cardiopulmonary process. EX 20.

Hospitalization records from Wellmont-Holston Valley Medical Center, Cardiac Catheterization Laboratory dated 2/1/99 and 2/3/99, reflecting treatment for atrial fibrillation. DX 31.

Arterial blood gas study from Russell County Medical Center dated 6/10/99. EX 17.

Discharge summary from Russell County Medical Center dated 6/12/99 reflecting primary discharge diagnosis of rapid atrial fibrillation with left ventricular failure. EX 18.

Examination report dated August 30, 1999 authored by Kellie Brooks, Family Nurse Practitioner, reflecting an assessment of "[d]yspnea and respiratory abnormalities." DX 31.

Russell County Medical Center records from 10/2/00 to 8/31/03 reflecting, *inter alia*, treatment for flare up of chronic bronchitis, bradycardia, decompensated congestive heart failure, and acute bacterial exacerbation of COPD. DX 31.

Chest x-ray report from Russell County Medical Center dated 10/27/00 reflecting no retrocardiac density, lungs well expanded and hyperlucent but free of active or acute disease, heart at upper limits of normal size. EX 22.

Chest x-ray report from Russell County Medical Center dated 6/18/01 reflecting impression of pulmonary hyperinflation and old granulomatous disease, cardiomegaly, and right retrocardiac density. EX 24.

CT scan report from Russell County Medical Center dated 10/31/00 reflecting no retrocardiac density, no parenchymal pulmonary abnormalities, and chronic hyperlucency with some parenchymal pulmonary scarring. EX 23.

CT report from Russell County Medical Center dated 6/20/01 reflecting impression of prominent left atrium and confluence of right pulmonary veins consistent with abnormality demonstrated on previous chest x-ray, old granulomatous disease with mediastinal and hilar lymph nodes unchanged, development of small right pleural effusion, and cholelithiasis. EX 21.

Examination report dated September 24, 2001 authored by Kellie Brooks, Family Nurse Practitioner, reflecting an assessment of coal workers' pneumoconiosis and COPD secondary to coal workers' pneumoconiosis. DX 31.

Treatment records of Pulmonary Associates of Kingsport dated 11/1/02, 4/22/03, and 8/19/03 reflecting treatment by Dr. Joseph F. Smiddy for "coal worker's pneumoconiosis with 100% total and permanent disability" and "chronic bronchitis, chronic shortness of breath, and wheeze." DX 31.

Pulmonary function study from Pulmonary Associates of Kingsport dated 9/14/04. EX 27.

Pulmonary function study from Pulmonary Associates of Kingsport dated 12/13/04. EX 28.

DISCUSSION AND APPLICABLE LAW

Subsequent Claim

As stated above, where a claimant has filed more than one claim and the earlier claim was denied, the later claim must also be denied on the grounds of the earlier denial unless the claimant demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. 20 C.F.R. § 725.309(d). Since Claimant previously failed to establish any condition of entitlement, the newly submitted evidence must now establish that one of the conditions of entitlement has changed since the prior denial of May 27, 1998.

Employer now concedes that Claimant has established a disabling respiratory impairment and has thus established a change in condition since the prior denial of his claim. Employer's Closing Argument and Brief at 17. After a review of the newly submitted evidence, I find Employer's concession is proper in that the vast majority of the medical opinion evidence supports a finding of total disability. Both Drs. Hippensteel and Castle, Employer's medical experts, found that Claimant suffers from a respiratory impairment which would preclude him from returning to his former job as a "car dropper" in the coal mines. DX 37, EX 29, 33, 34. Similarly, Dr. Henry, Claimant's treating physician for the past ten years, concluded that Claimant had a significant respiratory impairment. DX 31. Although Dr. Baker, the physician who conducted a pulmonary examination of Claimant on behalf of the Department of Labor, characterized Claimant's respiratory impairment as only "moderate," he gave no explanation for this assessment and his opinion is thus not well reasoned. I therefore find that Claimant has demonstrated an element of entitlement which was previously adjudicated against him. The entire evidentiary record must thus be reviewed *de novo* to determine whether Claimant is entitled to benefits.

In his May 27, 1998 Decision and Order Denying Benefits, which is the last final decision of record prior to the filing of the instant claim for benefits, Administrative Law Judge Richard A. Morgan fully and accurately described the medical evidence then of record. DX 1 (DX 41). His description of that evidence is incorporated herein by reference.

With respect to evidence submitted between Judge Morgan's decision and when the instant claim was filed, as I noted earlier, Claimant filed requests for modification on April 5, 1999, June 8, 2000, and August 20, 2001. Inasmuch as Claimant's subsequently filed "withdrawal" of his claim was ineffective, the evidence filed by the parties between May 27, 1998 and July 11, 2003 must also be considered to the extent such evidence is not excluded by operation of the Department's regulations which became effective January 19, 2001. The admissible evidence previously filed during this period includes the following:

A. X-Ray reports

Exhibit	Date of X-ray	Quality	Physician/ Qualifications	Interpretation
DX 1 (DX 56)	8/26/97	1	Scott, BCR/B	Negative
DX 1 (DX 56)	8/26/97	1	Wheeler, BCR/B	Negative
DX 1 (DX 37)	10/22/98	1	Alexander, BCR/B	1/1
DX 1 (DX 53)	10/22/98	2	Cooper, B	No CWP
DX 1 (DX 56)	10/22/98	1	Scott, BCR/B	Negative

DX 1 (DX 56)	10/22/98	2	Wheeler, BCR/B	Negative
DX 1 (DX 56)	3/26/99	2	Scott, BCR/B	No CWP
DX 1 (DX 56)	3/26/99	2	Wheeler, BCR/B	No CWP
DX 1 (DX 49)	5/28/99	2	Ahmed, BCR/B	1/1
DX 1 (DX 55)	5/28/99	2	Gaziano, B	No CWP
DX 1 (DX 58)	5/28/99	1	Barrett, BCR/B	No CWP
DX 1 (DX 48)	7/1/99	1	Fino, B	Negative
DX 1 (DX 53)	7/1/99	1	Scott, BCR/B	No CWP
DX 1 (DX 66)	9/11/00	2	Castle, B	No CWP
DX 1 (DX 64)	3/27/01	1	Barrett, BCR, B	No CWP
DX 1 (DX 61)	6/20/01	U/R	Nania, BCR/B	Images of thorax are for mediastinum and not for lung fields; no comment can be made about CWP.
DX 1 (DX 63)	7/24/01	1	Barrett, BCR, B	No CWP

B. Pulmonary Function Studies

Exhibit	**Physician**	**Age/ Height**	**FEV_1**	**FVC**	**MVV**	**FEV_1/ FVC**	**Date of Study**	**Comments**
DX 1 (DX 37 & 42)	Craven	61 74”	2.23	3.19		70%	8/17/98	Moderate obstruction; low vital capacity possibly from concomitant restrictive defect.
DX 1 (DX 60)	McSharry	63 74”	2.31 2.40	3.29 3.52	58	70% 68%	7/1/99	
DX 1 (DX 49)	Craven		2.20	3.26		69%	7/26/99	Moderate obstruction; low vital capacity possibly from concomitant restrictive defect.
DX 1 (DX 51)	Craven	63 74”	2.04	3.19		64%	6/21/00	Moderate obstruction; low vital capacity possibly from concomitant restrictive defect.
DX 1 (DX 66)	Castle	63 73”	2.02 2.07	3.00 3.09	84	67% 67%	9/11/00	Valid studies although FVC maneuver terminated early; spirometry shows mild-moderate airway obstruction without changes after bronchodilator; lung volumes show hyperinflation and gas trapping; diffusion normal.

C. Arterial Blood Gas Studies

Exhibit	Date	Physician	pCO_2	pO_2	Resting/ Exercise	Comments
DX 1 (DX 44)	3/26/99	Lewis	47.6	66.0	Resting Exercise	
DX 1 (DX 60)	7/1/99	McSharry	40.0	76.5	Resting Exercise	Completely normal ABGs at rest.
DX 1 (DX 66)	9/11/00	Castle	44.4	77.1	Resting Exercise	Resting ABGs are normal; carboxy-hemoglobin level normal.

D. Narrative Medical Evidence

Dr. Roger J. McSharry

Dr. McSharry, who is Board-certified in Internal Medicine, Pulmonary Medicine, and Critical Care Medicine, conducted a pulmonary evaluation of Mr. Culbertson on July 1, 1999 at Employer's request and reported his findings in a report dated July 6, 1999. DX 1 (DX 60). He noted relevant occupational and medical histories and a smoking history of ½ pack of cigarettes daily for 25 years which ended a year ago. His evaluation also included conducting a review of available medical records and performing diagnostic testing including chest x-ray, pulmonary function tests, and arterial blood gas studies. Dr. McSharry concluded, particularly based on the radiographic and pulmonary function test results, that Claimant did not suffer from coal workers' pneumoconiosis. He further found that Claimant did suffer from a moderate obstructive and non-reversible pulmonary disease which was likely caused by tobacco abuse but not by exposure to coal dust. Dr. McSharry noted that there had been a decrease in pulmonary function over the past several years which was typically seen in COPD from tobacco abuse, and he also noted that prior arterial blood gas studies were unremarkable. He opined that Claimant's moderate COPD would "likely prevent him from performing the duties of a car dropper as they have been described to me."

Dr. Ernest N. Henry

According to a June 21, 2000 letter from Dr. Henry responding to Claimant's representative, Mr. Culbertson had "obvious shortness of breath with minimal exertion. . . , obvious respiratory impairments. . . [and] hospitaliz[ation] with recurring attacks of bronchitis." DX 1 (DX 57). He further stated that a 5/26/00 chest x-ray showed increased fibrotic lung findings in both lungs with "no obvious honeycombing." Dr. Henry reported that a 1997 pulmonary function test was not indicative of upper airway obstruction and was instead more consistent with pneumoconiosis. He believed Claimant's breathing impairment resulting from "significant pneumoconiosis" limiting his activities of daily living.

Dr. James R. Castle

Dr. Castle prepared a report dated September 29, 2000 regarding his pulmonary examination of Mr. Culbertson on September 11, 2000 at Employer's request. DX 1 (DX 66). He noted Claimant's relevant work and medical histories, and recorded a smoking history of about ½ pack of cigarettes daily between the ages of about 18 and two years ago resulting in about a 21 pack-year smoking history. Dr. Castle's evaluation included a physical examination, a chest x-ray, pulmonary function study, and arterial blood gas studies, and a review of the available medical evidence including treatment records, medical reports, and other objective test results. Based on a review of these records and his examination of Claimant, he opined with a reasonable degree of medical certainty that Mr. Culbertson did not suffer from coal workers' pneumoconiosis. He determined that Claimant's 21 pack year smoking history was sufficient to have caused COPD. He noted that Claimant had a history of coronary artery disease and atrial fibrillation which can result in symptomatic shortness of breath, particularly with exertion. He further noted that Claimant did not demonstrate consistent physical findings, such as findings of rales, crackles, or crepitations, indicating the presence of an interstitial pulmonary process. Dr. Castle concluded that the vast majority of radiologists and B-readers found no evidence whatsoever of any form of pneumoconiosis and that the most recent x-ray showed a suggestion of abnormality in the right lower lung zone which was not pneumoconiosis. He also noted that Claimant's arterial blood gas studies were essentially normal and the valid physiologic studies which had been performed showed a mild to moderate degree of airway obstruction without restriction or diffusion abnormality, which changes were related to Claimant's smoking history. Finally, Dr. Castle concluded that Claimant was "probably" totally disabled as a result of tobacco smoke induced COPD, but was not disabled as a result of any process arising from his coal mining employment.

E. Hospital and Treatment Records

Russell County Medical Center chest x-ray report dated 8/26/97 reflecting no active or acute cardiopulmonary process. DX 1 (DX 59).

Russell County Medical Center chest x-ray report dated 10/22/98 noting no active or acute cardiopulmonary process. DX 1 (DX 59).

Russell County Medical Center blood gas report dated 6/10/99 noting PCO_2 of 35.5 and PO_2 of 77.0. DX 1 (DX 59).

Russell County Medical Center discharge summary dated 6/12/99 noting diagnosis of rapid atrial fibrillation with left ventricular failure. DX 1 (DX 59).

Holston Valley Medical Center records showing admission on 3/13/00 for painful knees bilaterally. DX 1 (DX 59).

Chest x-ray interpretation by Dr. Joseph F. Smiddy dated 3/27/01 noting, *inter alia*, "prominent rounded densities [in retrocardiac area], some of which are calcified and some of which are not calcified." DX 1 (DX 57).

Progress note by Dr. Joseph F. Smiddy from Pulmonary Associates of Kingsport dated 3/27/01 reflecting diagnoses of pneumoconiosis, chronic bronchitis, and "multiple rounded densities particularly in the retrocardiac area on lateral with underlying pneumoconiosis and a broad differential diagnosis under consideration." DX 1 (DX 57).

Russell County Medical Center CT scan report dated 6/20/01 reflecting impression of prominent left atrium and confluence of right pulmonary veins, old granulomatous disease with mediastinal and hilar lymph nodes unchanged, development of small right pleural effusion, and cholelithiasis. DX 1 (DX 57).

Report of follow-up office visit by Dr. Joseph F. Smiddy dated 7/24/01 noting, *inter alia*, diagnoses of "apparent enlargement of retrocardiac mass with underlying pneumoconiosis, chronic bronchitis, old granulomatous changes, and cardiomegaly." DX 1 (DX 57).

Pneumoconiosis and Causation

The new regulatory provisions at 20 C.F.R. § 718.201 contain a modified definition of "pneumoconiosis" and they provide the following:

(a) For the purposes of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical," pneumoconiosis and statutory, or "legal," pneumoconiosis.
  (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
  (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coalmine dust exposure.

20 C.F.R. § 718.201. Section 718.202(a) provides four methods for determining the existence of pneumoconiosis. Each shall be addressed in turn.

Under section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (en banc); *Casella v. Kaiser Steel Corp.*, 9 BLR 1-131 (1986). As noted above, I also may assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP,* 12 BLR 1-6 (1988); *Clark*, 12 BLR 1-149 (1989).

The chest x-ray evidence submitted by the parties with respect to Claimants prior claims up to the time of Judge Morgan's May 27, 1998 decision is fully described in that decision. *Culbertson v. Clinchfield Coal Co.*, ALJ No. 97-BLA-1268, slip op. at 4-6 (May 27, 1998) ("ALJ Morgan Decision and Order"). None of the twenty-four interpretations listed therein support a finding of pneumoconiosis.

With respect to the evidence submitted since Judge Morgan's decision, the record contains an additional twenty-six interpretations of thirteen chest x-rays. For the reasons set forth below, I find that the chest x-ray evidence is insufficient to establish pneumoconiosis under 20 C.F.R. § 718.202(a)(1).

An August 26, 1997 chest x-ray was interpreted by Drs. Scott and Wheeler, both dually-qualified physicians, as negative for pneumoconiosis. DX 1 (DX 56). There are no contrary readings. This x-ray thus cannot support a finding of pneumoconiosis.

An October 28, 1998 chest x-ray was read as negative for coal workers' pneumoconiosis by three physicians, Drs. Cooper, Scott and Wheeler. DX 1 (DX 53, 56). Dr. Cooper is a B-reader while both Drs. Scott and Wheeler are dually-qualified physicians. The only contrary reading is by Dr. Alexander, who is also a dually-qualified physician. DX 1 (DX 37). Given the number of unfavorable interpretations and the qualifications of the physicians who read the film as negative for the disease, I find that this x-ray evidence does not support a finding of pneumoconiosis.

A March 26, 1999 chest x-ray was interpreted by Drs. Scott and Wheeler, both dually-qualified physicians, as negative for pneumoconiosis. DX 1 (DX 56). There are no contrary readings. This x-ray thus cannot support a finding of pneumoconiosis.

A May 28, 1999 chest x-ray was read as negative for coal workers' pneumoconiosis by two physicians, Drs. Gaziano and Barrett. DX 1 (DX 55, 58). Dr. Gaziano is a B-reader while Dr. Barrett is a dually-qualified physician. The only contrary reading is by Dr. Ahmed, who is also dually-qualified. DX 1 (DX 49). Given the similar qualifications of Drs. Ahmed and Barrett, and the negative reading of the film by a qualified B-reader, I find that this x-ray evidence does not support a finding of pneumoconiosis.

The four chest x-rays dated July 1, 1999, September 11, 2000, March 27, 2001, and July 24, 2001 were read by five physicians, all of whom are B-readers and three of whom are dually-qualified, as negative for pneumoconiosis. DX 1 (DX 48, 53, 63, 65, 66). Another chest x-ray dated June 20, 2001 was found by a dually-qualified physician to be unreadable and thus incapable of supporting a diagnosis for the disease. DX 1 (DX 61). None of these x-rays support a finding of pneumoconiosis.

There are eight interpretations of the four most recent chest x-rays submitted by the parties with respect to the instant claim.

A March 19, 2001 x-ray was read as negative by Dr. Wheeler and positive, with a profusion of 1/0, by Dr. Cappiello. Both physicians are dually-qualified, and I thus find this evidence to be in equipoise and incapable of supporting a finding of pneumoconiosis.

Another film dated December 9, 2003 was also read by two physicians. Dr. Baker, a B-reader, found the x-ray positive for the disease with a profusion of 1/0. Dr. Scatarige read the same film as completely negative for the disease. Given Dr. Scatarige's superior qualifications, as both a B-reader and a Board-certified radiologist, I give more weight to his findings and thus find that this x-ray does not support Mr. Culbertson's claim.

A May 13, 2004 x-ray was read a negative for pneumoconiosis by Dr. Wheeler and as positive for the disease with a profusion of 1/0 by Dr. Miller. Both physicians are dually-qualified. In a two-page letter dated April 14, 2005 (EX 30), filed by Employer as "rehabilitative" evidence, Dr. Wheeler gave multiple reasons why he disagreed with Dr. Miller's interpretation of this x-ray. He noted, for example, that Dr. Miller's interpretation of the film quality as overexposed was incorrect since the degree of exposure in the film was necessary to see details in the lower lungs. He further noted that Dr. Miller neglected to mark the ILO form for either small opacities or profusion and the profusion of opacities noted in his narrative report was not consistent with the distribution of coal workers' pneumoconiosis which involves small round nodules in the central portion of the mid and upper lungs. Dr. Wheeler also stated that Dr. Miller misinterpreted thickened pleura on the right and left lateral chest walls as minimal extrapleural fat in a person who is obese, and he misinterpreted pulmonary vessels in the mid and lower lungs as nodules. I find Dr. Wheeler's explanations reasonable and thus accord his interpretation more weight than the contrary opinion of Dr. Miller. Even without Dr. Wheeler's supplemental statement, however, the readings of the May 13, 2004 x-ray would be in equipoise given the qualifications of these two physicians. Under either circumstance, the x-ray does not support a finding of pneumoconiosis.

Finally, the most recent x-ray of record is dated March 23, 2005 and was interpreted by Dr. Wheeler as negative for coal workers' pneumoconiosis and as positive by Dr. Ahmed with a profusion of 1/0. Since both physicians are dually-qualified, I find this evidence to be in equipoise and insufficient to support a finding of pneumoconiosis.

Based on the foregoing, I find that the x-ray evidence viewed both individually and as a whole does not support a finding of pneumoconiosis.

Since the record does not contain either biopsy or autopsy evidence, Claimant cannot establish pneumoconiosis pursuant to § 718.202(a)(2).

None off the three presumptions identified in § 718.202(a)(3) are applicable to the instant claim, and Claimant thus cannot establish pneumoconiosis pursuant to § 718.202(a)(3).

Section 718.202(a)(4) provides the fourth and final way to prove that the miner has or had pneumoconiosis. Under this section, Claimant may establish the existence of the disease if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffered from pneumoconiosis. Although the x-ray evidence may be negative for pneumoconiosis, a physician's reasoned opinion may support the presence of the disease if it is supported by adequate rationale besides a positive x-ray interpretation. *See Trumbo v. Reading Anthracite Co.*, 17 BLR 1-85, 1-89 (1993); *Taylor v. Director, OWCP*, 1-22, 1-24 (1986). The weight given to each medical opinion will be in proportion to its documented and well-reasoned conclusions.

A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Fuller v. Gibraltar Coal Corp.*, 6 BLR 1-1291 (1984). A report may be adequately documented if it is based on items such as a physical examination, symptoms, and a patient's history. *See Hoffman v. B & G Construction Co.*, 8 BLR 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 BLR 1-295 (1984); *Buffalo v. Director, OWCP*, 6 BLR 1-1164, 1-1166 (1984); *Gomola v. Manor Mining and Contracting Corp.*, 2 BLR 1-130 (1979).

A "reasoned" opinion is one in which the underlying documentation and data are adequate to support the physician's conclusions. *See Fields, supra*. The determination that a medical opinion is "reasoned" and "documented" is for the fact-finder to determine. *See Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 BLR 1-1292 (1984). *See also Phillips v. Director, OWCP*, 768 F.2d 982 (8th Cir. 1985); *Smith v. Eastern Coal Co.*, 6 BLR 1-1130 (1984); *Duke v. Director, OWCP*, 6 BLR 1-673 (1983) (a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis); *Waxman v. Pittsburgh & Midway Coal Co.*, 4 BLR 1-601 (1982).

Judge Morgan fully described the medical opinion evidence of record at the time of his May 27, 1998 decision. ALJ Morgan Decision and Order at 8-10. With respect to the medical opinion evidence, he wrote:

> Dr. Paranthaman was the only physician in this case to diagnose CWP. He did so in November 1986. His qualifications are unknown. He had only his examination and a "0/1" x-ray reading available. More qualified physicians, i.e., Drs. Castle and Sargent have ruled out CWP. Mr. Culbertson's physical examinations have generally shown "clear lungs." Drs. Cox, Chambers, Ketron, Griffith, and Tan, who treated Mr. Culbertson for various maladies over the years never once mentioned CWP. X-ray readings before and after the one relied on by

> Dr. Paranthaman convincingly erode the basis for his diagnosis. The physicians have established that Mr. Culbertson's afflictions are: cigarette-smoking induced mild obstructive airways impairment or chronic bronchitis; paroxysmal atrial fibrillation; and, degenerative arthritis.

Id. at 14. Based on his review of this evidence, Judge Morgan found that Claimant had failed to sustain his burden to prove the existence of pneumoconiosis. *Ibid*. After an independent review of this same evidence, I concur in Judge Morgan's assessment, and thus find that this evidence does not establish that Claimant suffers from either legal or clinical pneumoconiosis.

Since Mr. Culbertson's claim was last denied in May 1998, seven medical opinions have been added to the record: three favorable opinions, one by Dr. Baker and two by Dr. Henry; and four negative opinions, two by Dr. Castle, and one each by Drs. McSharry and Hippensteel. As explained below, I find the medical opinion evidence submitted since Judge Morgan's decision does not support a finding of pneumoconiosis.

With respect to the opinion of Dr. Baker, the physician who examined Claimant on behalf of the Department of Labor, he rendered diagnoses of, *inter alia*, coal workers' pneumoconiosis based on an abnormal chest x-ray and exposure to coal dust, as well as COPD and chronic bronchitis, which he attributed to coal dust exposure and smoking. DX 13. To the extent Dr. Baker relied on x-ray evidence to support his diagnosis, that reliance is misplaced inasmuch as I have found the weight of the chest x-ray evidence does not support a finding of pneumoconiosis. Furthermore, exposure to coal dust is not, in and of itself, sufficient to establish pneumoconiosis. *See, e.g., Sahara Coal Co. v. Fitts*, 39 F.3d 781, 783 (7th Cir. 1994) ("Occupational exposure is not evidence of pneumoconiosis . . . but merely a reason to expect that evidence might be found."). Since Dr. Baker cited no other clinical findings or objective results to support his diagnosis of pneumoconiosis, or which would substantiate any causal connection between COPD or chronic bronchitis and Mr. Culbertson's coal mine employment, I find his opinion is not well reasoned and thus give it little weight.

I similarly find the two opinions of Dr. Henry, Claimant's treating physician, are not reasoned, nor are they well documented. In his one-page letter dated June 21, 2000, he wrote that a 5/26/00 chest x-ray showed increased fibrotic lung findings in both lungs with "no obvious honeycombing" and reported that a 1997 pulmonary function test was not indicative of upper airway obstruction and was instead more consistent with pneumoconiosis. DX 1 (DX 57). Neither finding, however, supports his diagnosis of pneumoconiosis. First, as noted above, the x-ray evidence both before and after Dr. Henry authored his opinion is contrary to a finding of pneumoconiosis. Furthermore, pulmonary function studies are not diagnostic of the presence or absence of pneumoconiosis. *See, e.g., Burke v. Director*, *OWCP*, 3 B.L.R. 1-410 (1981). Although Dr. Henry notes various respiratory symptoms such as shortness of breath, chronic cough and wheezing, he does not expressly associate these symptoms with pneumoconiosis. Similarly, he states that Claimants "25 year history of working in the coal mines with exposure of coal dust . . . plays a large part in his dyspnea," but gives no rationale for this conclusion. No other explanation for his diagnosis of pneumoconiosis is provided. Nor does his one-page October 6, 2002 letter provide any further rationale for his conclusion that Mr. Culbertson suffers from pneumoconiosis, again relying on x-ray evidence, pulmonary function studies, occupational

exposure to coal dust, and Claimant's "significant respiratory impairment . . . ." DX 31. Neither opinion is well reasoned, and they are thus insufficient to meet Claimant's burden of establishing pneumoconiosis.[14]

None of the remaining four opinions of record support a finding of pneumoconiosis. Dr. McSharry conducted a pulmonary evaluation of Claimant and reported his findings in a report dated July 6, 1999. DX 1 (DX 60). Although he found that Mr. Culbertson suffered from a moderate obstructive and non-reversible pulmonary disease, he determined that it was not due to Claimant's exposure to coal dust but was instead likely caused by Claimant's smoking history of ½ pack of cigarettes daily for approximately 25 years. Dr. Castle reached a similar conclusion in his opinions dated September 22, 2000 and March 23, 2005 after twice examining Claimant, as did Dr. Hippensteel after examining Claimant on May 13, 2004. DX 1 (DX 66), EX 29. All four of these physicians performed a physical examination and conducted x-rays, pulmonary function studies, and arterial blood gas tests. All four physicians found, consistent with my findings in this decision, that the x-ray evidence obtained during their examinations, as well as other available x-ray evidence, was inconsistent with a diagnosis of pneumoconiosis. Furthermore, all four physicians explained why the results of the pulmonary function studies and arterial blood gas tests supported their conclusions that Claimant's respiratory impairment was unrelated to his exposure to coal mine dust. For example, Dr. Hippensteel testified at deposition that pulmonary function testing revealed moderate obstruction with minimal improvement post bronchodilator, Claimant's total lung volume capacity was completely normal, he had an essentially normal lung diffusion capacity, and Mr. Culbertson's symptoms were due to chronic bronchitis and obstructive lung disease caused by smoking and heart disease, all of which were unrelated to coal mine dust exposure. EX 33 at 21-24, 28. Dr. Castle similarly testified at deposition that results of arterial blood gas studies were normal and pulmonary function test results were consistent with obstructive but not restrictive lung disease. EX 34 at 14-17. He further noted that, although coal mine dust may result in a reduction of diffusion capacity, that was typically seen in the presence of a high degree of profusion of either p or r type opacities on chest x-ray which was not seen in Claimant's case. *Id.* at 16. He concluded that Claimant did not suffer from coal workers' pneumoconiosis or any other chronic dust disease of the lungs related to or aggravated by coal dust exposure but instead had a respiratory impairment due to smoking, cardiac problems, and obesity. *Id.* at 17. All four of these physician opinions are thorough, well reasoned, consistent with each other, and consistent with the objective medical evidence of record. Therefore, even if Claimant had submitted sufficient evidence to establish that he had pneumoconiosis, which he has not, the contrary medical opinions of record would outweigh Claimant's evidence.

[14] I also note that various hospital and treatment records in the evidentiary record reflect diagnoses of, *inter alia*, pneumoconiosis, COPD, and bronchitis. *See, e.g.*, DX 31 (assessment of coal workers' pneumoconiosis and COPD secondary to coal workers' pneumoconiosis by Family Nurse Practitioner Kelly Brooks); DX 31 (treatment records of Dr. Joseph Smiddy reflecting "coal worker's pneumoconiosis with 100% total and permanent disability" and "chronic bronchitis, chronic shortness of breath, and wheeze"); DX 1 (DX 57) (progress note by Dr. Smiddy reflecting diagnoses of pneumoconiosis, chronic bronchitis, and "multiple rounded densities particularly in the retrocardiac area on lateral with underlying pneumoconiosis and a broad differential diagnosis under consideration"). However, none of these records give any explanation for these diagnoses other than x-ray evidence, pulmonary function studies, and coal mine employment which, for all the reasons mentioned above, do not support a finding of either legal or clinical pneumoconiosis in this case.

Based on all the foregoing reasons, I thus find that Claimant has failed to establish that he suffers from pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(1)-(4).

Since Claimant has not established the presence of pneumoconiosis, he cannot establish that he has pneumoconiosis which arose out of his coal mine employment.

As noted above, Claimant has established a totally disabling respiratory or pulmonary impairment under the provisions of Section 718.204(b). However, Claimant must also establish total disability due to pneumoconiosis as required by Section 718.204(c). Under the circumstances of this case, I find Claimant has not submitted evidence sufficient to establish that he is totally disabled due to pneumoconiosis as required by Section 718.204(c).

Accordingly, since Claimant has not established the presence of pneumoconiosis or that his totally disabling respiratory impairment is due to pneumoconiosis, this claim for benefits must be denied

Attorney's Fee

The award of an attorney's fee under the Act is permitted only in cases in which the Claimant is found to be entitled to benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for representation services rendered to the Claimant in pursuit of this claim.

ORDER

The claim of Raymond K. Culbertson for benefits under the Act is, hereby, DENIED.

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STEPHEN L. PURCELL
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefit Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on Allen Feldman, Esq., Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C., 20210.